

# Provider Enrollment

## Additional Providers Within the Practice

<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Last Name, First, MI	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Medical License No.  <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Medicaid Provider No.	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Title (MD, DO, ND, NP, PA) (Provider must have prescription writing privileges)	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Specialty (Peds, Family Med, GP, Other (Specify))
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**For State use only:**

Immunization Program Representative:	Date Certified for Prevention Partnership:
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